STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155412	A. BUILDING _____ B. WING _____	C 05/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD HEALTH AND LIVING COMMUNITY	937 FRY RD GREENWOOD, IN 46142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaint IN00148862 and IN00148895.

Complaint IN00148862 - Substantiated. No deficiencies related to the allegations were cited.

Complaint IN00148895 - Substantiated. No deficiencies related to the allegations were cited.

Survey date: May 19 & 20, 2014

Facility number: 000509
Provider number: 155412
AIM number: 100266620

Survey team:
Susan Worsham, RN, TC

Census bed type:
SNF: 4
SNF/NF: 98
Total: 102

Census payor type:
Medicare: 12
Medicaid: 69
Other: 21
Total: 102

Sample:

Greenwood Health and Living was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regards to the Investigation of Complaints IN00148862 and IN00148895.

Quality Review 05/21/14 by Lisa McColly

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD HEALTH AND LIVING COMMUNITY	**937 FRY RD GREENWOOD, IN 46142**

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